

DISCHARGE PLANNING

Planning for a patient's discharge and successful return to the community begins at the time of admission. Inpatient and Day Treatment professional staff are responsible for assessing when a patient no longer meets the Center's admission criteria.

Procedures for discharging patients are as follows:

Inpatient and Partial Hospitalization:

- 1) The treatment team makes the decision to discharge the patient.
- 2) If applicable, the Administrative Agent will be contacted.
- 3) The primary therapist, or designated staff, will notify the family and/or significant others of the decision to discharge and the date of discharge.
- 4) The risk assessment will be completed.

- 5) The discharge/aftercare forms will be completed by the physician and primary therapist or designate respectively.
- 6) The patient, guardian, or significant other will be given a copy of the discharge/aftercare forms.
- 7) The chart shall be completed, including the Discharge Summary, within 15 days following discharge. The Discharge Summary shall include:
 - a) Admission date
 - b) Discharge date
 - c) From which unit patient is discharged and to where
 - d) Identification data
 - e) Chief complaint and history of present illness
 - f) Diagnostic work-up and significant findings
 - g) Physical condition on admission and discharge
 - h) Lab, x-ray, special procedures
 - i) Clinical course
 - j) Condition on discharge
 - k) Discharge diagnosis
 - l) Recommendations
 - m) Risk Assessment document